This document provides an overview of all the community services (adults and children’s & families) provided by the Central London Community Healthcare NHS Trust in Merton.

We recommend that you use the link provided to access this document, rather than printing copies locally. That way, you will always be accessing the most up-to-date version.

*Sept 2019 edition*
## Contents

How to refer .................................................................................................................... 3

### Adult services ........................................................................................................... 5
  - Case management ................................................................................................... 6
  - Community domiciliary therapies ........................................................................ 7
  - Community nursing ............................................................................................... 8
  - Community bed-based intermediate care ............................................................. 9
  - Community home-based intermediate care ......................................................... 10
  - Continence ............................................................................................................. 11
  - Integrated sexual health services ......................................................................... 12
  - Dementia ................................................................................................................ 13
  - Diabetes .................................................................................................................. 14
  - Dietetics ................................................................................................................ 15
  - End of life care ....................................................................................................... 16
  - St Raphael’s Hospice referral criteria .................................................................. 17
  - Falls prevention ..................................................................................................... 18
  - Cardiology ............................................................................................................. 19
  - HIV ........................................................................................................................ 20
  - Holistic assessment and rapid investigation (HARI) ............................................. 21
  - Neurotherapies ..................................................................................................... 23
  - Podiatry ................................................................................................................ 24
  - Podiatric surgery .................................................................................................. 26
  - Rapid response: Merton enhanced rapid intervention team (MERIT) .............. 27
  - Respiratory ........................................................................................................... 28
  - Speech and language therapy (SLT) ................................................................... 29
  - Tissue viability ....................................................................................................... 30

### Children’s and family services .............................................................................. 31
  - SPECTRA .............................................................................................................. 32
  - Children’s dietetics ............................................................................................... 33
  - Children’s occupational therapy .......................................................................... 34
  - Children’s physiotherapy ..................................................................................... 35
  - Children’s safeguarding team .............................................................................. 36
  - Children’s speech and language therapy ............................................................. 37
  - Family nurse partnership (FNP) .......................................................................... 38
  - Health visiting ...................................................................................................... 39
  - School nursing ...................................................................................................... 40
How to refer

Adult services

Making a high quality referral that includes all key clinical information will help to improve your patients’ experience and make their clinical treatments more effective. To ensure all referrals are of the highest quality, we have tailored the referral process to meet the specific needs of our services and service users.

CLCH has a dedicated single point of access (SPA) for adult services in Merton, through which all referrals and messages should be channelled.

The Adult SPA contact details are:

- **Referrers’ phone line:** 0333 004 7555 (local number rate)
- **Patients’ phone line:** 0333 241 4242 (local number rate)
- **Email:** clcht.mertonspa@nhs.net
- **Efax:** 0300 008 2122
- **Address** PO Box 130, Morden, SM4 9EF

Please note that we will stop receiving referrals by fax in accordance with the Department of Health’s directive on the cessation of use of faxes by 1/4/2020.

The Merton adult services’ SPA phone line is open Monday to Friday 8am to 6pm. Written referrals can be sent via email outside these hours and will be processed when we are next open.

**GP referrers**

Please select and complete one of our 3 referral forms available on Ardens / QMaster (all services referral form, podiatry referral form and diabetes referral form), and email it over to us.

If you use these forms then a verbal referral is not necessary. We advise that you ensure that we have safely received the referral in CLCH, by requesting both a delivery and read receipt to your email, and following up if you don’t receive these.

You are also advised to call the SPA on 0333 004 7555 to check for safe receipt of **clinically urgent** or **clinically high risk referrals**; but this is just a quick call to say “have you received this?” rather than a full verbal referral and this call can safely be made by anyone in the practice.
Other referrers

How to make a written referral to the adult specialist teams:

1. Download the appropriate referral form from the CLCH website: [https://clch.nhs.uk/health-professionals/merton](https://clch.nhs.uk/health-professionals/merton)
2. Fax, email or post the referral form using the details above.

Some services require verbal referrals. If this is the case please, the process is:

1. Call the Merton adult services SPA on 0333 004 7555 (Mon-Fri 8am-6pm).
2. Provide the referral details requested by the administrator.
3. You will be asked specific questions to clarify the service required for your patient and will be required to provide specific paperwork, which will be clarified at the time of the call.
4. Email the required paperwork to clcht.mertonspa@nhs.net or fax to 0300 008 2122 within the timescale specified during the initial call before the referral can be accepted.

Children’s and family services

For children’s and family services referrals, contact details are provided on the individual service pages in this directory.

More details of how to refer to individual services are provided on the CLCH website: [https://clch.nhs.uk/health-professionals/merton](https://clch.nhs.uk/health-professionals/merton)

We are constantly aiming to improve the services that we provide and welcome any feedback on our referral process.
Case management

Overview
We provide individual-centred case management, care and treatment to housebound and non-housebound patients with long term and/or chronic conditions, a physical and mental health, social, psych-social, isolation, non-engaging, substance misuse and medicines care needs in their local communities, patients' home or residential care settings. The care is designed to suit the needs of the patient, giving them the confidence to be in control of their health and to be more independent.

Service objective
The service provides case management for Merton adults over the age of 18 years. The case manager carries out a holistic assessment of the referred individual's health and wellbeing care needs. We then provide a comprehensive range of clinical and non-clinical interventions that enable individuals to avoid unnecessary visits to the GP, A&E and admission to hospital, or where hospitalisation is necessary, to support discharge back into the community.

Case management acts as a single point of contact for care which includes assessment, planning of care, support, advice and information for individuals, ensuring improved health and wellbeing and overall quality of life.

Inclusion criteria
- Over 18 years of age and registered with a Merton GP.
- Unstable long term conditions impacting on an individual's quality of life.
- Frequent A+E and/or GP attendance in last 12 months.
- Very high intensity user of inpatient secondary services.
- Requires co-ordination and sign posting of health and social care needs.
- Socially isolated.
- Mild/moderate mental health issues.
- Recent hospital admission.
- Requires medicine and/or chronic disease management.

Exclusion criteria
- Acutely unwell.
- Nursing home residents.
- Individuals at the end stage of life.

Referral details

<table>
<thead>
<tr>
<th>Age range</th>
<th>Is patient self-referral available? Yes</th>
<th>Are home visits available? Yes</th>
<th>Service contact (SPA)</th>
<th>Is transport provided? No</th>
<th>How to refer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 18 years of age</td>
<td></td>
<td></td>
<td>PO Box 130</td>
<td></td>
<td>See ‘how to refer’ page 3.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Morden SM4 9EF</td>
<td></td>
<td>Non GP referrers are required to refer verbally and then provide appropriate written information to support the referral.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>T 0333 004 7555</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>E <a href="mailto:clcht.mertonspa@nhs.net">clcht.mertonspa@nhs.net</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>F 0300 008 2122</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Community domiciliary therapies

Overview
The community domiciliary therapies service is provided within each of the locality teams. Patients may be referred by GPs, consultants and any other health professionals and agencies working within the community. The team is made up of various therapists including physiotherapists and occupational therapists. The therapist will provide a holistic assessment in the patient's home and work in collaboration with locality colleagues, other agencies and/or the patient's carer to support the individual in regaining or maintaining their independence at home.

Service objective
The service is designed to improve a patient's mobility, independence and quality of life by identifying their goals and needs in their own homes. This may be in response to recent orthopaedic surgery, falls, musculo-skeletal injury or a long term condition. The therapist will undertake a detailed assessment of rehabilitation needs and develop a personal rehabilitation/care plan in agreement with the patient and/or carer. This could range from regaining outdoor mobility, to indoor mobility, managing stairs, setting up a maintenance programme, to reviewing and advising on method of transfer including manual handling. The service is able to provide advice regarding maintenance, but is unable to provide ongoing therapy.

Inclusion criteria
- Housebound, unable to access outpatient physiotherapy.
- Over 18 years of age and registered with a Merton GP.
- Need for rehabilitation and/or advice to support the patient in regaining independence or in managing an ongoing condition to optimise mobility, independence and physical comfort.

Exclusion criteria
- Patients whose needs would be more appropriately met by another service e.g. have a neuro-rehabilitation or pulmonary rehabilitation need.
- Patients requiring urgent input to avoid hospital admission should be referred to MERIT (Merton enhanced rapid intervention team).

Referral details

<table>
<thead>
<tr>
<th>Age range</th>
<th>Is patient self-referral available?</th>
<th>Are home visits available?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 18 years of age</td>
<td>No</td>
<td>This is a home based service</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service contact (SPA)</th>
<th>Is transport provided?</th>
<th>How to refer</th>
</tr>
</thead>
<tbody>
<tr>
<td>PO Box 130 Morden SM4 9EF</td>
<td>No</td>
<td>See ‘how to refer’ page 3.</td>
</tr>
<tr>
<td>T 0333 004 7555</td>
<td></td>
<td>Non GP referrers are required to refer verbally and then provide appropriate written information to support the referral.</td>
</tr>
<tr>
<td>E <a href="mailto:clcht.mertonspa@nhs.net">clcht.mertonspa@nhs.net</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F 0300 008 2122</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Community nursing

Overview
The community nursing service provides non-emergency nursing assessments, care and treatment to housebound patients with a physical health care need within their local communities, including the patients’ home or residential care settings. The service supports and encourages people with disabilities and long-term conditions to live independent lives.

Service objective
The service provides nursing care for housebound adults over the age of 18 years. It provides a comprehensive range of treatments that enable individuals to avoid unnecessary admission to hospital, or where hospitalisation is necessary, to support discharge back into the community. Nursing care includes the assessment and planning of care for patients, ensuring proactive advice and information.

Inclusion criteria
- Housebound patients
- Over 18 years of age and registered with a Merton GP
- A specific nursing need

Exclusion criteria
- If a patient can easily access care within a clinical setting, for example GP practice or outpatients’ clinic, we recommend that the patient is not referred to community nursing.
- Patients requiring urgent input to avoid hospital admission should be referred to MERIT (Merton Enhanced Rapid Intervention Team)

Referral details

<table>
<thead>
<tr>
<th>Age range</th>
<th>Is patient self-referral available?</th>
<th>Are home visits available?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 18 years of age</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service contact (SPA)</th>
<th>Is transport provided?</th>
</tr>
</thead>
<tbody>
<tr>
<td>PO Box 130 Morden SM4 9EF T 0333 004 7555 E <a href="mailto:clcht.mertonspa@nhs.net">clcht.mertonspa@nhs.net</a> F 0300 008 2122</td>
<td>No</td>
</tr>
</tbody>
</table>

How to refer
See ‘how to refer’ page 3.
Non GP referrers are required to refer verbally and then provide appropriate written information to support the referral.
Community bed-based intermediate care

Overview
We provide a short term rehabilitation service to patients in bedded units prior to discharge back to their own home. Patients may be referred as supported discharges from hospital or admission avoidance from the community. The rehabilitation beds are located within nursing or residential homes, with daily therapy available weekdays.

Service objective
The supported discharge service is designed to improve a patient’s mobility and independence with activities of daily living to enable them to return to their own homes, with further rehabilitation and/or social support as required. A therapist will undertake a detailed assessment of rehabilitation needs and develop a personal rehabilitation plan in agreement with the patient e.g. mobility, stair practice, personal care, meal preparation. Admission avoidance patients will have short term rehabilitation and/or nursing needs, with the expectation of regaining a previous level of independence within a short time frame.

Inclusion criteria
- Over 65 years of age and registered with a Merton GP
- Have a planned discharge destination
- Supported discharge – short term rehabilitation needs and goals which cannot be met at home (may require assistance to transfer)
- Admission avoidance – short term rehabilitation and/or nursing needs (admission avoidance)
- Patients are able to participate in a personal rehabilitation/care programme, are motivated to regain their independence, and are able to achieve their goals for discharge back to their own home within 1-6 weeks

Exclusion criteria
- Patients who are not medically stable
- Patients who are unable to or unmotivated to engage with rehabilitation
- Clients who require respite/social services step down support
- We do not provide respite or convalescence care.

Referral details

<table>
<thead>
<tr>
<th>Age range</th>
<th>Is patient self-referral available?</th>
<th>Are home visits available?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 65 years of age</td>
<td>No</td>
<td>Home assessment or visit will be conducted prior to discharge from bedded units</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service contact (SPA)</th>
<th>Is transport provided?</th>
<th>How to refer</th>
</tr>
</thead>
<tbody>
<tr>
<td>PO Box 130 Morden SM4 9EF</td>
<td>Provided to prevent admission and on discharge if required</td>
<td>See ‘how to refer’ page 3. Non GP referrers are required to refer verbally and then provide appropriate written information to support the referral.</td>
</tr>
<tr>
<td>T 0333 004 7555</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E <a href="mailto:clcht.mertonspa@nhs.net">clcht.mertonspa@nhs.net</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F 0300 008 2122</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Community home-based intermediate care

Overview
We provide a short term rehabilitation service to patients in their own home. Patients may be referred as supported discharges from hospital or admission avoidance from the community. The rehabilitation team provides up to three visits daily to support patients in regaining their independence at home.

Service objective
The service is designed to improve a patient’s mobility and independence with activities of daily living in their own homes, and identify further rehabilitation and/or social support as required. A therapist will undertake a detailed assessment of rehabilitation needs and develop a personal rehabilitation plan in agreement with the patient e.g. mobility, stair practice, personal care, meal preparation.

Inclusion criteria
- Over 18 years of age and registered with a Merton GP
- Medically stable
- Short term rehabilitation needs and goals and currently housebound
- Patients are able to participate in a personal rehabilitation programme, are motivated to regain their independence, and are able to achieve their goals within 2-6 weeks.

Exclusion criteria
- Patients who are not medically stable
- Patients who are unable to or unmotivated to engage with rehabilitation
- Clients who require respite/social services step down support
- We do not provide respite or convalescence care.

Referral details

<table>
<thead>
<tr>
<th>Age range</th>
<th>Is patient self-referral available?</th>
<th>Are home visits available?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 18 years of age</td>
<td>No</td>
<td>This is a home based service</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service contact (SPA)</th>
<th>Is transport provided?</th>
<th>How to refer</th>
</tr>
</thead>
<tbody>
<tr>
<td>PO Box 130 Morden SM4 9EF</td>
<td>Provided to prevent admission and on discharge if required</td>
<td>See ‘how to refer’ page 3.</td>
</tr>
<tr>
<td>T 0333 004 7555</td>
<td></td>
<td>Non GP referrers are required to refer verbally and then provide appropriate written information to support the referral.</td>
</tr>
<tr>
<td>E <a href="mailto:clcht.mertonspa@nhs.net">clcht.mertonspa@nhs.net</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F 0300 008 2122</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Continence

### Overview
The continence service provides care to adults with complex continence issues over the age of 18 years. It provides a comprehensive range of interventions that enables individuals to become self-caring and independent, or to adapt and modify their lifestyles to enable them to adjust to increasing dependence. The service initiates and reviews interventions, supports patients and acts as an information resource for the multidisciplinary team.

### Service objective
The service offers education programmes to healthcare professionals. Patients can be seen in a range of settings including their own homes, nursing and residential homes, clinics and GP practices. Continence products will only be supplied where a continence assessment has been carried out within the agreed guidelines.

### Inclusion criteria
For new patients:
- Over 18 years of age and registered with a Merton GP
- A specific continence need

### Exclusion criteria
Patients under 18 years

### Referral details

<table>
<thead>
<tr>
<th>Age range</th>
<th>Is patient self-referral available?</th>
<th>Are home visits available?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 18 years of age</td>
<td>Patients can self-refer if they have previously been known to the team.</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service contact (SPA)</th>
<th>Is transport provided?</th>
<th>How to refer</th>
</tr>
</thead>
<tbody>
<tr>
<td>PO Box 130 Morden SM4 9EF T 0333 004 7555 E <a href="mailto:clcht.mertonspa@nhs.net">clcht.mertonspa@nhs.net</a> F 0300 008 2122</td>
<td>No</td>
<td>See ‘how to refer’ page 3.</td>
</tr>
</tbody>
</table>
Integrated sexual health services

Overview
The service is jointly commissioned with Wandsworth and Richmond local authority and provides sexual health and reproductive services across the three boroughs. Localised community based clinics deliver the non specialised aspects of care whilst clients requiring complex contraception or assessment and treatment for symptomatic sexually transmitted infections are seen within our level 3 service at Clapham Junction. The service provides clinics within Merton on an appointment only basis which offer a full range of contraceptive methods including long acting reversible contraception (LARC), asymptomatic sexual health screening and advice. The Hub clinic at Clapham Junction offers open access walk in clinics for all.

Service objective
To enhance the sexual and reproductive health of the local population especially those at groups at risk of poor sexual health. This includes offering a choice of effective methods of contraception to meet individual needs and provision of accessible and high quality sexual health services. We participate in the national chlamydia screening programme. The service offers a level three open access service for complex and specialist care within the Hub based at Clapham Junction.

Inclusion criteria
The general clinics are for people of any age needing contraception or sexual health advice.

Exclusion criteria
Referrals to the psychosexual medicine service may not be appropriate if the sexual problem is associated with any psychiatric morbidity or personality disorder.

Referral details

<table>
<thead>
<tr>
<th>Age range</th>
<th>Is patient self-referral available?</th>
<th>Are home visits available?</th>
<th>How to refer:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open access</td>
<td>Yes</td>
<td>No (except in exceptional circumstances)</td>
<td>Patients without symptoms can order a self testing kit online by visiting our website at: <a href="https://www.shswl.nhs.uk/">https://www.shswl.nhs.uk/</a></td>
</tr>
</tbody>
</table>

Contact details
All appointments, referrals and enquiries are made through our Single Point of Access
T: 0333 300 2100
Website [https://www.shswl.nhs.uk/](https://www.shswl.nhs.uk/)
Merton clinics based at:
- Patrick Doody Clinic, 79 Pelham Road, Wimbledon SW19 1NX
- Wideway Medical Centre, Wideway, Mitcham, CR41BP

<table>
<thead>
<tr>
<th>Is transport provided?</th>
<th>How to refer:</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>Patients can book an appointment by calling SPA on 0333 300 2100 or online at <a href="https://www.shswl.nhs.uk/">https://www.shswl.nhs.uk/</a>. Details of walk in clinics are also available on the website.</td>
</tr>
</tbody>
</table>

GP referrals can be made by letter to clcht.shsspa@nhs.net
Dementia

Overview
The community dementia nurse service provides specialist nursing care and support for people with a diagnosis of dementia and their carers to improve their overall health and wellbeing. We facilitate best practice dementia care through a coordinated and integrated approach across Merton health and social care providers and the voluntary sector. Through expert biopsychosocial assessment, psycho-education, advanced communication skills, psychosocial engagement and the offer of advance care planning, we support people at all the stages of dementia. We employ a person-centred approach to care, promoting people’s wishes and preferences to optimise their quality of life.

Service objectives
- To provide person-centred dementia care and support for people with dementia and their carers, both pre and post diagnosis.
- To provide access to cognitive stimulation therapy, to slow the rate of cognitive decline in people with dementia.
- To offer advance care planning and promote self-determination for people with dementia.
- To facilitate good quality end-of-life care for people with dementia.
- To provide training and education in dementia, thereby improving the confidence of staff in delivering care to secure the best possible outcomes for people with dementia.
- To avoid unplanned hospital admissions and inappropriate care homes placements.

Inclusion criteria
- Registered with a Merton GP

Referral details

<table>
<thead>
<tr>
<th>Age range</th>
<th>Is patient self-referral available?</th>
<th>Are home visits available?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 18 years of age</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Service contact (SPA)
PO Box 130
Morden SM4 9EF
T 0333 004 7555
E clcht.mertonspa@nhs.net
F 0300 008 2122

<table>
<thead>
<tr>
<th>Is transport provided?</th>
<th>How to refer</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>See ‘how to refer’ page 3.</td>
</tr>
</tbody>
</table>
**Diabetes**

**Overview**
The community diabetes service consists of a multidisciplinary team of consultants, specialist nurses, dietitians and podiatrists. Patients with type 1 and type 2 diabetes in Merton can access multidisciplinary clinics managed by the diabetes team. We also provide support to patients (and their carers) in the homes of housebound patients and in residential or nursing homes.

The service provides structured education programmes for all patients with Type 1 & Type 2 diabetes in a variety of community locations as well as one-to-one educational support.

**Service objective**
We strive to improve access to high quality expert diabetes care and reduce health inequalities for Merton patients with diabetes. Our team helps patients control their diabetes and reduce the risk of short and long term complications by providing them with the skills, knowledge and confidence to self-manage their diabetes effectively.

We work closely with GPs, social services, learning disabilities teams, mental health teams and other healthcare professionals involved in a patient's healthcare – we can also provide clinical support for GPs and practice nurses within the surgery. Joint appointments can be arranged at home with the dietitian, specialist nurse and community nurse so that we can work together to ensure best care and advice possible to our patients. We can refer onto retinal screening and secondary care and can also book interpreting services to accompany patients during the consultation.

**Inclusion criteria**
- Over 18 years of age unless referred by paediatric diabetes services.
- Registered with a Merton GP.
- The patient must have a clear diagnosis of diabetes.

**Exclusion criteria**
- People with unstable complications of diabetes or complications that require immediate medical attention.
- Pregnant women.

These patients should be referred to Tier 4 services at local acute trusts.

**Referral details**

<table>
<thead>
<tr>
<th>Age range</th>
<th>Is patient self-referral available?</th>
<th>Are home visits available?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 18 years of age</td>
<td>Not yet</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service contact (SPA)</th>
<th>Is transport provided?</th>
<th>How to refer</th>
</tr>
</thead>
<tbody>
<tr>
<td>PO Box 130 Morden SM4 9EF</td>
<td>No</td>
<td>See 'how to refer' page 3.</td>
</tr>
<tr>
<td>T 0333 004 7555</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E <a href="mailto:cicht.mertonspa@nhs.net">cicht.mertonspa@nhs.net</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F 0300 008 2122</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Dietetics

Overview
The community dietetics service provides nutritional management for patients referred with clinical conditions and helps prevent further complications. The service supports patients and carers to achieve agreed nutritional related goals.

Service objective
To provide a high quality service which incorporates the use of evidence-based practice to improve quality of life. We aim to empower the patient through education, regarding their own role in facilitating and expediting recovery and wellbeing.

Inclusion criteria
- Over 18 years of age and registered with a Merton GP

Referral details

<table>
<thead>
<tr>
<th>Age range</th>
<th>Is patient self-referral available?</th>
<th>Are home visits available?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 18 years of age</td>
<td>No</td>
<td>Home visits are provided to patients who are unable to attend clinics provided in the community.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service contact (SPA)</th>
<th>Is transport provided?</th>
<th>How to refer</th>
</tr>
</thead>
<tbody>
<tr>
<td>PO Box 130 Morden SM4 9EF</td>
<td>No</td>
<td>See ‘how to refer’ page 3.</td>
</tr>
<tr>
<td>T 0333 004 7555</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E <a href="mailto:clcht.mertonspa@nhs.net">clcht.mertonspa@nhs.net</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F 0300 008 2122</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
End of life care

Overview
We provide care for patients within the anticipated last year of their lives across all care settings regardless of their diagnoses. The team supports and facilitates best practice through a coordinated and integrated approach across Merton community services and beyond, working closely with specialist palliative care services, which are largely provided by local hospices. Referral criteria for St Raphael’s Hospice is reproduced overleaf.

Service objective
The service aims to provide equitable and quality led end of life care across Merton community services, facilitating more people to have their end of life care preferences and wishes met through advanced care planning and promoting the creation of ‘Coordinate My Care’ (CMC) records. We also offer support to carers/families dealing with bereavement.

Supporting care homes with generalist end of life care education and training is an important role of the service, promoting the early identification those requiring end of life care in these environments.

Inclusion criteria
- Over 18 years of age and registered with a Merton GP.
- Life limiting diagnosis/terminal illness, expected to be within his/her last year of life.

Referral details

<table>
<thead>
<tr>
<th>Age range</th>
<th>Is patient self-referral available?</th>
<th>Are home visits available?</th>
<th>Is transport provided?</th>
<th>How to refer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 18 years of age</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>See ‘how to refer’ page 3. See St Raphael’s inclusion criteria overleaf</td>
</tr>
</tbody>
</table>

Service contact (SPA)
PO Box 130
Morden SM4 9EF
T 0333 004 7555
E clcht.mertonspa@nhs.net
F 0300 008 2122
## St Raphael’s Hospice referral criteria

<table>
<thead>
<tr>
<th>Patients need to satisfy either 1 and 2 below or 1 and 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Over 18 years of age and registered with a GP in either Merton, Sutton or parts of Wandsworth and live within the boroughs of Sutton or Merton.</td>
</tr>
<tr>
<td>2. People with a life-limiting (≤1 year) illness either due to a malignant or a non-malignant disease, who have complex needs requiring assessment and management by a specialist palliative care multi-disciplinary team.</td>
</tr>
<tr>
<td><strong>OR</strong></td>
</tr>
<tr>
<td>3. People with a longer prognosis but who have complex needs requiring assessment and management by a specialist palliative care team, when short-term intervention may be helpful.</td>
</tr>
</tbody>
</table>

### Hospice@Home

<table>
<thead>
<tr>
<th>Hospice@Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Hospice@Home aims to provide support for patients within the boroughs of Sutton and Merton who have expressed a wish to die at home or in their usual place of care such as a care home.</td>
</tr>
<tr>
<td>2. The service aims to facilitate fast track discharges from hospital and to prevent inappropriate hospital admissions.</td>
</tr>
<tr>
<td>3. Patients do not have to have a specialist palliative care need in order to be referred, but if there is felt to be a specialist palliative care need then the patient may be referred on to the CPCT for assessment.</td>
</tr>
<tr>
<td>4. Referrals are accepted from external sources such as GPs, DNs or hospital based palliative care teams or internally from the CPCT or the inpatient unit.</td>
</tr>
<tr>
<td>5. Patients must be 18 years or over, living in the boroughs of Sutton or Merton and be registered with a NHS Sutton or Merton GP.</td>
</tr>
<tr>
<td>6. Prognosis must be considered to be less than three months.</td>
</tr>
<tr>
<td>7. Patients must have consented to receive care at home (or the carer if patient unable to do so).</td>
</tr>
<tr>
<td>8. Patients’ preferred place of death is home.</td>
</tr>
<tr>
<td>9. In line with fast track discharges, patients should be referred to district nurses and have a continuing care package in place.</td>
</tr>
<tr>
<td>10. The care of the patients will be overseen by the band 6 RGN with support from the community services manager.</td>
</tr>
</tbody>
</table>

### Psychological and bereavement support

<table>
<thead>
<tr>
<th>Psychological and bereavement support</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Referral for psychological support is available to all patients under the care of the hospice, their relatives and carers.</td>
</tr>
<tr>
<td>2. Bereavement support is offered to all relatives/carers of patients who have been supported by the hospice.</td>
</tr>
</tbody>
</table>

**St Raphael’s Hospice specialist palliative care referral forms are available online:**

https://www.straphaels.org.uk/how-to-refer
Falls prevention

Overview
The service provides assessment, advice and exercise modalities for older people who are at risk of falling. This includes:

- Home response by a physiotherapist with a comprehensive assessment to give personalised falls prevention advice, which will include a home exercise plan and can make onward referrals for further interventions/advice
- “Staying Steady” exercise and advice classes in community settings (8 weeks)
- Otago type home exercise programme (8 weeks) for the less mobile (Zimmer frame users).

Service objective
The aim of the service is to increase an older person's ability to move and mobilise safely, increasing confidence and promoting active ageing. The service aims to prevent falls and unnecessary admission to hospital by seeing a patient before an injurious fall occurs or undertaking a maintenance programme after rehabilitation.

Inclusion criteria
- 18 years and over and registered with a Merton GP
- Patients must have had a fall, have a fear of falling or are at risk of falling

Exclusion criteria
- Medically unstable
- Needing rehabilitation – see holistic assessment and rapid intervention (HARI) service
- Receiving physiotherapy for falls from another service
- Unexplained falls or falls that need further investigation

Referral details

<table>
<thead>
<tr>
<th>Age range</th>
<th>Is patient self-referral available?</th>
<th>Are home visits available?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 18 years of age</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service contact (SPA)</th>
<th>Is transport provided?</th>
<th>How to refer</th>
</tr>
</thead>
<tbody>
<tr>
<td>PO Box 130 Morden SM4 9EF</td>
<td>Yes</td>
<td>See ‘how to refer’ page 3.</td>
</tr>
<tr>
<td>T 0333 004 7555</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E <a href="mailto:clcht.mertonspa@nhs.net">clcht.mertonspa@nhs.net</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F 0300 008 2122</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Cardiology

Overview
The cardiology service aims to provide evidence based treatment for patients with heart failure. This includes monitoring of the condition, behavioural modification, health promotion, specialist care to improve quality of life by slowing disease progression and improving symptoms to reduce mortality, preventing re-admission to hospital and improving palliative care provision for patients and carers.

Service objective
To provide evidence based treatment for patients with heart failure by taking an active role in titration of heart failure medication to optimum doses and by providing education and support for other healthcare professionals involved in the care of these patients to share their expertise. To provide cardiac rehabilitation programmes for patients.

Inclusion criteria
- Over 18 years of age and registered with a Merton GP
- A diagnosis of heart failure

Exclusion criteria
An unconfirmed diagnosis of heart failure

Referral details

<table>
<thead>
<tr>
<th>Age range</th>
<th>Is patient self-referral available?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 18 years of age</td>
<td>Patients can self-referral if they have previously been known to the team.</td>
</tr>
<tr>
<td>Are home visits available?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service contact (SPA)</th>
<th>Is transport provided?</th>
<th>How to refer</th>
</tr>
</thead>
<tbody>
<tr>
<td>PO Box 130</td>
<td>No</td>
<td>See ‘how to refer’ page 3.</td>
</tr>
<tr>
<td>Morden SM4 9EF</td>
<td></td>
<td></td>
</tr>
<tr>
<td>T 0333 004 7555</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E <a href="mailto:clcht.mertonspa@nhs.net">clcht.mertonspa@nhs.net</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F 0300 008 2122</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**HIV**

**Overview**
The HIV service provides support to adults, young people and families affected and living with HIV/AIDS and other blood-borne viruses in the community. The nurse-led service undertakes holistic assessments, treatment adherence, advice and education to people living with HIV/AIDS and hepatitis B and C.

**Service objective**
The aim of the HIV Service is to improve health outcomes for people with complex health needs due to HIV disease, particularly those diagnosed late and with opportunistic infections like tuberculosis, in order to prevent hospital admissions.

**Inclusion criteria**
- Registered with Merton GP
- Infected and affected by HIV and AIDS

**Services we offer**
- Advice, emotional support and provision of sexual health information
- Partner notification
- Contraception and sexual health information for women and men living with HIV
- Information on prevention of vertical transmission to pregnant and nursing mothers
- Condom distribution
- Anti-retroviral drug adherence support
- Holistic assessments of patients' needs and setting up care packages
- Promote point-of-care testing in the community to reduce late diagnosis, morbidity and mortality
- Onward referral to other professionals as necessary
- Support, information and advice to healthcare professionals, members of the public and clients regarding HIV issues

**Referral details**

<table>
<thead>
<tr>
<th>Age range</th>
<th>Is patient self-referral available?</th>
<th>Are home visits available?</th>
</tr>
</thead>
<tbody>
<tr>
<td>All ages</td>
<td>Patients can self-refer if they have previously been known to the team.</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service contact (SPA)</th>
<th>Is transport provided?</th>
<th>How to refer</th>
</tr>
</thead>
<tbody>
<tr>
<td>PO Box 130 Morden SM4 9EF T 0333 004 7555 E <a href="mailto:clcht.mertonspa@nhs.net">clcht.mertonspa@nhs.net</a> F 0300 008 2122</td>
<td>No</td>
<td>See ‘how to refer’ page 3.</td>
</tr>
</tbody>
</table>
Holistic assessment and rapid investigation (HARI)

Overview
The holistic assessment and rapid investigation (HARI) service is a multidisciplinary community service for adults with complex medical and rehabilitation needs based at the Nelson Health Centre. The aim of the service is to provide a holistic assessment which encompasses medical and rehabilitative needs.

There are two assessment and treatment options:
1. Medical (consultant physicians, advanced nurse practitioners, pharmacist) and therapy (physiotherapists, occupational therapists) holistic assessment, investigations and treatment for patients with complex medical conditions, co-morbidities and frailty
2. Therapy / nursing rehabilitation.

Service objectives
The objectives of the service are to keep people well, prevent unplanned hospital admissions, promote health and wellbeing, reduce the risk of falls, rehabilitate and enable independent living.

Inclusion criteria

Comprehensive geriatric assessment:
Medical issues involving more than one system or in the context of other multiple issues including:
- Rehabilitation
- Polypharmacy
- Medicines optimisation
- Memory issues, as part of other multiple condition. For new cognitive impairment alone, please refer to Merton memory services
- Falls investigation
- Complexity
- Moderate to severe frailty

Rehabilitation and nursing:
Potential clients should:
- have the ability to stand from a chair with minimal assistance or supervision
- be able to mobilise with a walking aid independently or with supervision for at least three metres
- cognitively be able to follow instructions and demonstrations in order to be able to fully participate in rehabilitation
- have multi-disciplinary needs: physiotherapy, occupational therapy, nursing

Exclusion criteria
- This is an ambulatory service therefore not suitable for patients who cannot access us via our transport service. Home visits may be offered following assessment as part of the treatment package.
## Referral details

<table>
<thead>
<tr>
<th>Age range</th>
<th>Initial appointment</th>
<th>Is patient self-referral available?</th>
<th>Are home visits available?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 18 years of age</td>
<td>Within 10 working days</td>
<td>No</td>
<td>Yes (therapy only)</td>
</tr>
</tbody>
</table>

**Service contact (SPA)**  
PO Box 130  
Morden SM4 9EF  
T 0333 004 7555  
E clcht.mertonspa@nhs.net  
F 0300 008 2122

**Is transport provided?**  
Transport is arranged for those who are unable to travel independently to the service.

**How to refer**  
See 'how to refer' page 3.
Neurotherapies

Overview
The community neurotherapies team provides specialist, multidisciplinary rehabilitation and care in the community for people with neurological conditions. This includes access to an early supported discharge pathway for stroke patients.

Service objective
We provide a specialised service to people with neurological conditions in the community in order to safeguard independence by:
- preventing inappropriate hospital stays
- maximising rehabilitation and recovery after illness or injury
- providing support to people with neurological conditions to improve everyday activities, including:
  - gait
  - position and posture
  - communication
  - speech and swallowing.

Inclusion criteria
- Housebound patients mainly with outpatient clinics for physiotherapy
- Over 18 years of age and registered with a Merton GP

Exclusion criteria
- Patients with a primary problem not related to or impacted on by their neurological diagnosis

Referral details

<table>
<thead>
<tr>
<th>Age range</th>
<th>Is patient self-referral available?</th>
<th>Are home visits available?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 18 years of age</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service contact (SPA)</th>
<th>Is transport provided?</th>
<th>How to refer</th>
</tr>
</thead>
<tbody>
<tr>
<td>PO Box 130 Morden SM4 9EF</td>
<td>No</td>
<td>See ‘how to refer’ page 3.</td>
</tr>
<tr>
<td>T 0333 004 7555</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E <a href="mailto:clcht.mertonspa@nhs.net">clcht.mertonspa@nhs.net</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F 0300 008 2122</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Podiatry

Overview
The Community Podiatry Service supports patients who have significant medical and podiatric needs which put their feet at risk of problems and ensures patients are assessed and treated within a suitable timeframe.

Patients accepted by the service receive a defined package of care and in most cases will be discharged once the issue has been resolved. Where appropriate the service aims to discharge most patients following brief intervention and most patients do not access the service on an ongoing basis.

The majority of service provision is delivered in clinic based settings. A domiciliary service is provided to housebound patients only. Patients who are able to attend GP/ dental/ hospital appointments etc. are not considered to be housebound.

The service aims to see urgent referrals within 5 working days so patients must be safe to wait for this timeframe. The service aims to see routine referrals within 20 working days.

Service objective
The service aims to maintain and improve mobility and help patients remain independent. The service also aims to treat and prevent complications for people that are considered high risk.

Inclusion criteria
- Over 18 years of age and registered with a Merton GP
- Patients with foot deformity and dermatological conditions including corns, callus and ingrowing toenails
- Patients at high risk as a result of conditions such as poor circulation and nerve damage
- People with diabetes with additional complications

Exclusion criteria
Patients with no significant relevant medical history AND low podiatric need will not be accepted by the service.

The exception to this would be if a patient is considered to be particularly vulnerable and at risk of not receiving the necessary care and support. This could be, but is not necessarily, if the patient is registered blind, homeless, housebound or an amputee.

The service does not provide interventions for people with corns, callouses and verrucae who have low medical needs. The only exception to this would be if corns/ callouses/ verrucae are significantly symptomatic and a range of interventions have already been tried.

The service is not able to provide interventions for those with fungal skin infections.

The podiatry service does not provide routine nail cutting and skin care unless specifically for high risk patients who are otherwise eligible for the service (such as high risk patients with diabetic or vascular pathology). A patient’s inability to touch his/ her toes does not warrant a referral for routine nail cutting/ skin care.
Referral details

<table>
<thead>
<tr>
<th>Age range</th>
<th>Is patient self-referral available?</th>
<th>Are home visits available?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 18 years of age</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service contact (SPA)</th>
<th>Is transport provided?</th>
<th>How to refer</th>
</tr>
</thead>
<tbody>
<tr>
<td>PO Box 130 Morden SM4 9EF</td>
<td>Yes for those who meet the DOH</td>
<td>See ‘how to refer’ page 3.</td>
</tr>
<tr>
<td>T 0333 004 7555</td>
<td>eligibility criteria for patient</td>
<td></td>
</tr>
<tr>
<td>E <a href="mailto:clcht.mertonspa@nhs.net">clcht.mertonspa@nhs.net</a></td>
<td>transport service</td>
<td></td>
</tr>
<tr>
<td>F 0300 008 2122</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please note

All acute podiatry conditions such as diabetic foot ulcers, Charcot foot etc. must be referred to acute specialists as these conditions fall outside the remit of community podiatry and are likely to require additional investigations and monitoring by medical professionals.

Biomechanics referrals

Referrals are accepted for a range of biomechanical needs, including:

- metatarsalgia (forefoot pain)
- achilles/ankle pain
- pes planus/cavus – symptomatic (flat/ highly arched foot)
- heel pain/arch pain
- hallux/bunion pain
- lower limb evaluation
- tendinopathies

Patients with minor biomechanical problems are **not** accepted by the service.
Podiatric surgery

Overview
Podiatric surgery is a specialist form of foot surgery performed by podiatric surgeons. For this service, podiatric surgery is performed using local anaesthetic and undertaken on a day-care basis (with the patient going home on the day of the operation).

Service objective
The aim is to avoid the need for referral to secondary care for podiatric surgery and to increase the level of surgery undertaken on a day case basis.

Inclusion criteria
- Over 18 years of age and registered with a Merton GP

Exclusion criteria
- Patients requiring general anaesthetic should be referred to orthopaedics
- Patients should therefore be carefully selected and pre-operative advice given

Referral details

<table>
<thead>
<tr>
<th>Age range</th>
<th>Is patient self-referral available?</th>
<th>Are home visits available?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 18 years of age</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

Service contact (SPA)
PO Box 130
Morden SM4 9EF
T 0333 004 7555
E elcht.mertonspa@nhs.net
F 0300 008 2122

Is transport provided?
No

How to refer
See ‘how to refer’ page 3.
Rapid response: Merton enhanced rapid intervention team (MERIT)

Overview
The community rapid response team (MERIT) is a multidisciplinary health team made up of advanced practitioner nurses, nurses, physiotherapists and occupational therapists. The service aims to urgently respond to patients in their homes to facilitate the prevention of unnecessary attendance at accident & emergency and/or admission to an acute hospital. The team strive to ensure that the patients receive appropriate treatment by utilising the links with community services, social services and voluntary agencies as necessary.

Service objective
Provide urgent assessment, intervention and advice on the appropriate pathway of care utilising links with community health services; social care and voluntary agencies to enable the patient to remain at home where possible. The service aims to facilitate the prevention of unnecessary attendance at accident & emergency and/or admission to an acute hospital.

Inclusion criteria
- Patients who are over the age of 18 years old and registered with a Merton GP.
- Patients who require urgent assessment to prevent inappropriate admission to hospital.
- Patients who have health needs or health and social needs.

Exclusion criteria
- An acute or unstable mental health diagnosis
- Identified as requiring social care intervention only

Referral details

<table>
<thead>
<tr>
<th>Age range</th>
<th>Is patient self-referral available?</th>
<th>Are home visits available?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 18 years of age</td>
<td>No</td>
<td>Yes, to assess patients’ functional ability within their home environment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service contact</th>
<th>Is transport provided?</th>
<th>How to refer</th>
</tr>
</thead>
<tbody>
<tr>
<td>PO Box 130, Morden SM4 9EF</td>
<td>No</td>
<td>Non GP referrers are required to refer verbally and then provide appropriate written information to support the referral.</td>
</tr>
<tr>
<td>T 0333 004 7555 and select option 2 Mon – Fri 8am – 6pm. T 0208 102 3333 Mon – Fr 6pm – 7pm and weekends and bank holidays 10am – 6pm</td>
<td>E <a href="mailto:clcht.mertonspa@nhs.net">clcht.mertonspa@nhs.net</a> F 0300 008 2122</td>
<td></td>
</tr>
</tbody>
</table>
Respiratory

Overview
The respiratory service specialises in the treatment and management of adults with respiratory disease within the community. The service supports the management of patients with respiratory disease/conditions, including monitoring, behavioural modification/health promotion, pulmonary rehabilitation and specialist care through one-to-one and class based sessions. A home oxygen service is also provided.

Service objective
The service aims to manage patients with respiratory disease more effectively in the primary care and community setting, working closely with other health professionals reduce hospital admissions. The respiratory service offers clinical support, management, education programmes and advice to patients and their families. Patients can be seen in a range of settings including their own homes, clinics and GP practices.

Inclusion criteria
- Over 18 years of age and registered with a Merton GP
- A diagnosis of respiratory disease

Exclusion criteria
- Patients who do not have a known respiratory disease

Referral details
<table>
<thead>
<tr>
<th>Age range</th>
<th>Is patient self-referral available?</th>
<th>Are home visits available?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 18 years of age</td>
<td>Patients can self-refer if they have previously been known to the team.</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service contact (SPA)</th>
<th>Is transport provided?</th>
<th>How to refer</th>
</tr>
</thead>
<tbody>
<tr>
<td>PO Box 130 Morden SM4 9EF</td>
<td>No</td>
<td>See ‘how to refer’ page 3.</td>
</tr>
<tr>
<td>0333 004 7555</td>
<td></td>
<td></td>
</tr>
<tr>
<td><a href="mailto:clcht.mertonspa@nhs.net">clcht.mertonspa@nhs.net</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0300 008 2122</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Speech and language therapy (SLT)

Overview
The Merton adult community speech and language therapy team (SLT) provide a service to adults with acquired communication, speech, eating, drinking and swallowing difficulties, in a community setting. The service provides client-centred assessment, intervention, treatment and education to clients, carers, professionals and other stakeholders.

Service objective
The service aims to deliver a high quality service incorporating the use of evidence based practice to improve quality of life. The aim is to empower the patient through education, regarding their own role in facilitating and expediting recovery and wellbeing. Tailored advice would be provided to each individual client taking into consideration their preferences, lifestyle and social factors.

Inclusion criteria
- 18 years and over and registered with a Merton GP

Referral details

<table>
<thead>
<tr>
<th>Age range</th>
<th>Is patient self-referral available?</th>
<th>Are home visits available?</th>
<th>Is transport provided?</th>
<th>How to refer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 18 years of age</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>See ‘how to refer’ page 3</td>
</tr>
</tbody>
</table>

Service contact (SPA)
PO Box 130
Morden SM4 9EF
T 0333 004 7555
E clcht.mertonspa@nhs.net
F 0300 008 2122

Back to contents page
Tissue viability

Overview
The tissue viability service provides assessment, treatment and advice to healthcare professionals caring for patients with complex wounds including pressure ulcers, leg ulcers, fungating wounds and post-operative wounds. The service also offers education programmes, advice on larval therapy, topical negative pressure and the management of lower limb lymphoedema.

Service objective
To educate all community nursing staff to be able to prevent tissue viability issues and to be able to manage patients when tissue viability has been compromised. To provide an expert resource to manage highly complex patients with compromised tissue viability and wounds. Patients can be seen in a range of settings including their own homes, nursing and residential homes and GP practices.

Inclusion criteria
- Over 18 years of age and registered with a Merton GP
- Patients who have a complex non-healing wound

Exclusion criteria
- Referrals for specialist dermatology advice

Referral details

<table>
<thead>
<tr>
<th>Age range</th>
<th>Is patient self-referral available?</th>
<th>Are home visits available?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 18 years of age</td>
<td>Patients can self-refer if they have previously been known to the team.</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service contact (SPA)</th>
<th>Is transport provided?</th>
<th>How to refer</th>
</tr>
</thead>
<tbody>
<tr>
<td>PO Box 130 Morden SM4 9EF T 0333 004 7555 E <a href="mailto:clcht.mertonspa@nhs.net">clcht.mertonspa@nhs.net</a> F 0300 008 2122</td>
<td>No</td>
<td>See ‘how to refer’ page 3.</td>
</tr>
</tbody>
</table>
Children’s and family services

Our children’s services link into the wider health and social care economy and are built around keeping children safe. We aim to assist children and their families and we help children to develop by providing access to services that meet their needs. We offer a comprehensive service for all children, delivered in schools, clinics and children’s centres.
SPECTRA

Overview
SPECTRA deliver sexual health services to young people in Merton via an outreach, prevention, and engagement programme. They offer outreach support and education to young people in Merton in a range of educational and community settings.

Services include 121 support around sexual health and related issues, mentoring, STI screening – including HIV testing, and contraception support. Spectra will also deliver training to other professionals around sexual health, contraception and young people, and have expertise and services for trans and non-binary people, including social support groups and counselling for this group.

Service objective
The aim of this service is to improve the sexual health/wellbeing of the population of Merton’s young people and to contribute to reducing teenage pregnancies.

Inclusion criteria
- Young people aged 13 to 19 years who live work socialize or are in education in Merton

Exclusion criteria
- Young people not in this age group or demographic

Referral details

<table>
<thead>
<tr>
<th>Age range</th>
<th>Is patient self-referral available?</th>
<th>Are home visits available?</th>
</tr>
</thead>
<tbody>
<tr>
<td>13-19 years</td>
<td>Yes</td>
<td>No (except in exceptional circumstances)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service contact</th>
<th>Is transport provided?</th>
<th>How to refer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cat Archer</td>
<td>N/A</td>
<td>Drop-in sessions or to refer contact Cat Archer, Young Person’s Sexual Health Coordinator, Merton</td>
</tr>
<tr>
<td><a href="mailto:E-cat@spectra-london.org.uk">E-cat@spectra-london.org.uk</a></td>
<td></td>
<td><a href="mailto:cat@spectra-london.org.uk">cat@spectra-london.org.uk</a></td>
</tr>
</tbody>
</table>
Children’s dietetics

Overview
This is a targeted and specialist service to children and young people who require specialist input to meet their nutritional requirements. Dieticians assess and treat diet and nutrition problems at an individual level to enable children and their families to make appropriate lifestyle and food choices. We see children with a range of nutritional needs. Children with very complex health needs may be visited at home. Regular dietetics clinics are held at Perseid School in Merton.

Service objective
To provide a specialist dietetic service with individual tailored advice and supportive literature to assist meeting the child’s health needs and encourage age appropriate growth and development.

Inclusion criteria
- 0 to 19 years (up to 25 years for complex needs) and registered with a Merton GP
- Allergies (e.g. milk, wheat, egg, peanut, tree nuts, soya, fish) and intolerances (e.g. lactose intolerance), coeliac disease, nutrition related constipation, faltering growth, nutritional management of dysphagia, eating/feeding difficulties (fussy eating) and physical or learning disabilities which impact on children’s ability to eat/may require enteral feeding via a nasogastric, nasojejunal or gastrostomy tube.

Exclusion criteria
- Children and young people who are overweight or obese who require a specific programme incorporating dietary advice or for those presenting with an eating disorder.

Referral details

<table>
<thead>
<tr>
<th>Age range</th>
<th>Is patient self-referral available?</th>
<th>Are home visits available?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-19 years (up to 25 years for complex needs)</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Contact details
Children and young people’s dietetics service
Cricket Green Polyclinic
4 Birches Close
Mitcham CR4 4LQ
T 03300539264
E clcht.mertonicnteam@nhs.net

<table>
<thead>
<tr>
<th>Is transport provided?</th>
<th>How to refer</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>Health referral by email</td>
</tr>
</tbody>
</table>
Children’s occupational therapy

Overview
The children’s occupational therapy service is a targeted and specialist service working within the general community and at the special schools within Merton. The service aims to meet the needs of children who may have functional difficulties resulting from conditions such as co-ordination difficulties, cerebral palsy, developmental delay, muscular dystrophy, Down’s syndrome, other neurological difficulties, autistic spectrum disorder, or sensory integration dysfunction. The service operates from Cricket Green Polyclinic in Mitcham and at Perseid School in Merton for children attending this school.

Service objective
To work with children to help improve their function and encourage independence to an appropriate level for their abilities in the areas of self-care (e.g. feeding and dressing), school work and leisure. To help parents and school staff understand why the child has functional difficulties and be able to give them tools to help them manage this well.

Inclusion criteria
- 0-19 years (up to 25yrs for complex needs) and registered with a Merton GP
- Children and young people requiring health support and outcomes for one or a combination of physical, functional, special school nursing or communication needs.

Exclusion criteria
- Adaptations to the home or equipment needed for the home. Please refer to occupational therapy services in Merton.

Referral details

<table>
<thead>
<tr>
<th>Age range</th>
<th>Is patient self-referral available?</th>
<th>Are home visits available?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-19 years (up to 25 years for complex needs)</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contact details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children and young people’s Occupational therapy service Cricket Green Polyclinic 4 Birches Close Mitcham CR4 4LQ T 03300539264 E <a href="mailto:clcht.mertonicnteam@nhs.net">clcht.mertonicnteam@nhs.net</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is transport provided?</th>
<th>How to refer</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>Health referral by email</td>
</tr>
</tbody>
</table>
Children’s physiotherapy

Overview
The children’s physiotherapy service provides a targeted and specialist service working within the community with children and young people who have a delay in their gross motor skills (e.g. not walking, problems with running); a neurological impairment (e.g. cerebral palsy); difficulties with balance and coordination or musculoskeletal disorders (fractures, strains, pain). In addition the service works with children and young people who have complex medical needs (e.g. wheelchair users).

The team consists of physiotherapists, some of whom are specialist and some highly specialist, plus therapy assistants. All our physiotherapists are registered with the Health and Care Professions Council (HCPC). Our therapy assistants receive additional training in therapy techniques and approaches needed for their individual role. The service is delivered at the polyclinic in Mitcham, at home where children have very complex health needs and in schools, nurseries and children’s centres if that is part of the therapy. A physiotherapy service is provided at Perseid School for children with profound and multiple learning difficulties.

Service objective
The aim of children’s physiotherapy is to encourage each child to optimise their physical potential so that maximal function is achieved, deformity prevented or reduced and the effect of disability is minimised.

Inclusion criteria
- 0 to 19 years (up to 25 years for complex needs) and registered with a Merton GP
- Musculoskeletal services include children and young people who have acute injuries e.g. sports injuries, fractures or sprains in limbs, joints and ligaments, Scoliosis, Perthes’ disease and adolescent growth pain, chronic pain, gait problems, orthopaedic and lower limb conditions e.g. talipes, torticollis and back conditions, developmental dysplasia of the hips, rheumatological conditions e.g. juvenile idiopathic arthritis and respiratory conditions e.g. chronic chest and lung conditions and cystic fibrosis.

Referral details

<table>
<thead>
<tr>
<th>Age range</th>
<th>Is patient self-referral available?</th>
<th>Are home visits available?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 19 years (up to 25 years for complex needs)</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contact details</th>
<th>Is transport provided?</th>
<th>How to refer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children and young people’s physiotherapy service Cricket Green Polyclinic 4 Birches Close Mitcham CR4 4LQ T 03300539264 E <a href="mailto:clcht.mertonicnteam@nhs.net">clcht.mertonicnteam@nhs.net</a></td>
<td>No</td>
<td>Health referral by email</td>
</tr>
</tbody>
</table>
**Children’s safeguarding team**

**Overview**
The aim of this team is to ensure that all children we come into contact with are safe and can lead fulfilled and meaningful lives.

**Service objective**
This service is managed by CLCH’s head of safeguarding and is led locally by a named nurse with the support of safeguarding children’s supervisors. The aim of the service is to support, supervise and advise staff of their duties in relation to child protection and safeguarding children.

**Inclusion criteria**
- Any member of staff who has a concern about safeguarding children can access support from this team

**Exclusion criteria**
- There is no specific exclusion criteria for safeguarding services

**Referral details**

<table>
<thead>
<tr>
<th>Age range</th>
<th>Is patient self-referral available?</th>
<th>Are home visits available?</th>
<th>Contact details</th>
</tr>
</thead>
</table>
| 0-18 years and families | No | No | Merton community services safeguarding children’s team  
Merton Civic Centre  
London Road,  
Morden SM4 5DX  
T 020 8545 4033 / 4048 / 4053  
E clcht.safeguardingchildrensmerton@nhs.net |

<table>
<thead>
<tr>
<th>Is transport provided?</th>
<th>How to refer</th>
</tr>
</thead>
</table>
| No | T 020 8545 4033 / 4048 / 4053  
E clcht.safeguardingchildrensmerton@nhs.net |
Children’s speech and language therapy

Overview
The service provides assessment, diagnosis and treatment for children with speech, language and communication difficulties. The service is delivered from health clinics in Merton or in schools, nurseries and children’s centres if that is part of their therapy. Where children have complex health needs they may be visited at home.

Service objective
The aim of the service is to promote the health aspect of speech, language and communication development of children to their best potential and support carers and educators in this process. CLCH works closely with the borough of Merton’s SLT team.

Inclusion criteria
- 0 to 19 years (up to 25 years for complex needs) and registered with a Merton GP
- Children and young people with health needs including: speech, language and communication disorder/specific language impairment, difficulties in sound production, dysfluency (stammering), selective mutism, communication difficulties arising from cleft palate, hearing impairment, visual impairment and eating and drinking difficulties including dysphagia (swallowing).

Referral details

<table>
<thead>
<tr>
<th>Age range</th>
<th>Is patient self-referral available?</th>
<th>Are home visits available?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 19 years (up to 25 years for complex needs)</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contact details</th>
<th>Is transport provided?</th>
<th>How to refer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children and young people’s speech and language therapy service Cricket Green Polyclinic 4 Birches Close Mitcham CR4 4LQ T 03300539264 E <a href="mailto:clcht.mertonicnteam@nhs.net">clcht.mertonicnteam@nhs.net</a></td>
<td>No</td>
<td>Health referral by email</td>
</tr>
</tbody>
</table>
Family nurse partnership (FNP)

Overview
The family nurse partnership (FNP) is a voluntary programme offered to young mothers having their first baby; it begins in early pregnancy and is orientated to the future health and wellbeing of the child.

Service objective
The FNP programme is an intensive home visiting programme for pregnant young women under the age of 24, expecting their first baby. It is designed to work with the young mothers from 16 weeks gestation to the child’s second birthday. The programme is grounded in three theories; whereby behaviour change is the underpinning philosophy.

Our FNP nurses develop therapeutic relationships with the teenagers, facilitating greater understanding of pregnancy, childbirth, and sensitive responsive parenting. The programme has been imported from America where outcomes include a reduced incidence of child abuse and neglect, fewer childhood injuries, reduced premature and low birth weight babies, reduced smoking in pregnancy and increased breast feeding.

Ideally we would like referrals before 12-14 weeks gestation.

Inclusion criteria
- All mothers aged 19 years or under at last menstrual period
- Young mothers 24 and under with known vulnerabilities (SS/DV/Lac/SEN/etc)
- First pregnancy – including if a previous pregnancy ended in miscarriage/stillbirth/termination
- Under 28 weeks gestation
- Living within the London Borough of Merton
- No planned adoption
- Client needs to be aware of the referral and consent obtained

Exclusion criteria
- Women over 24 years of age (referrals for clients aged 20-24 should have detailed information on known vulnerabilities)
- If a client has already had a child
- If a client is over 28 weeks gestation

Referral details

<table>
<thead>
<tr>
<th>Age range</th>
<th>Is patient self-referral available?</th>
<th>Are home visits available?</th>
<th>How to refer</th>
</tr>
</thead>
<tbody>
<tr>
<td>24 years of age or under</td>
<td>Yes</td>
<td>Yes</td>
<td>T 020 8102 5362 / 07920 835 638 E <a href="mailto:clicht.fnpmerton@nhs.net">clicht.fnpmerton@nhs.net</a></td>
</tr>
</tbody>
</table>

Contact details
Family nurse partnership
The Acacia children’s centre
230 Grove Road
Mitcham CR4 1SD
T 020 8102 5362 / 07920 835 638
E clicht.fnpmerton@nhs.net
Health visiting

Overview
Health visitors provide a high quality and effective community based public health nursing service which delivers health promotion in line with healthy child programme targets, to improve the health outcomes for children and parents. Health visitors work in close partnership with families and other agencies to ensure all children are safeguarded. Targeted intervention is instigated following health assessments.

Service objective
To provide a universal service that allows ease of access for families to timely, evidence-based advice and support to enable positive outcomes for families and young children.

Inclusion criteria
- Health visiting is a universal service covering all children who live in the London Borough of Merton

Exclusion criteria
- Children over the age of 5 or who are in reception at school

Referral details

<table>
<thead>
<tr>
<th>Age range</th>
<th>Is patient self-referral available?</th>
<th>Are home visits available?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 years and families</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contact details</th>
<th>Is transport provided?</th>
<th>How to refer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Merton children’s services administration</td>
<td>No</td>
<td>T 03300539264 E <a href="mailto:clcht.hcpadminmerton@nhs.net">clcht.hcpadminmerton@nhs.net</a></td>
</tr>
<tr>
<td>Lavender Steers Mead</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lavender Park Pavilion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lavender Avenue Mitcham CR4 3HL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>T 03300539264 E <a href="mailto:clcht.hcpadminmerton@nhs.net">clcht.hcpadminmerton@nhs.net</a></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
School nursing

Overview
The school nurse works across health and education, providing a link between school, home and the community to benefit the health and wellbeing of children and young people. The school nurse promotes health to individuals and the school population and works in collaboration with teachers, youth workers and social care.

Service objective
The core school nursing service includes screening the children in reception and weighing and measuring the children in Year 6 and following up identified health needs.

School nurses work with vulnerable children and young people where a health need has been identified and can support school staff to manage chronic health needs, such as epilepsy, asthma, or other medical conditions.

Inclusion criteria
- School nursing is a universal service covering all children who attend a state maintained school and academies in the London Borough of Merton
- Specialist services such as enuresis clinics are available to children and young people who live or have a GP in Merton

Exclusion criteria
- Children that attend private schools.

Referral details

<table>
<thead>
<tr>
<th>Age range</th>
<th>Is patient self-referral available?</th>
<th>Are home visits available?</th>
</tr>
</thead>
<tbody>
<tr>
<td>School age children and young people attending school in Merton</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service contact</th>
<th>Is transport provided?</th>
<th>How to refer</th>
</tr>
</thead>
<tbody>
<tr>
<td>School nursing service</td>
<td></td>
<td>T 020 8274 5266</td>
</tr>
<tr>
<td>Lavender Steers Mead</td>
<td></td>
<td>E <a href="mailto:clcht.schoolnursingmerton@nhs.net">clcht.schoolnursingmerton@nhs.net</a></td>
</tr>
<tr>
<td>Lavender Park Pavilion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lavender Avenue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mitcham CR4 3HL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>T 020 8274 5266</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E <a href="mailto:clcht.schoolnursingmerton@nhs.net">clcht.schoolnursingmerton@nhs.net</a></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>